MEDICAL STATEMENT FOR ADULT PARTICIPANTS WITHOUT DISABILITIES in the Child and Adult Care Food Program (CACFP)

This medical statement is for nondisabled participants who require special dietary accommodations to CACFP meals. **This form must be completed in its entirety and submitted to the CACFP adult day care center before the CACFP facility can make any meal substitutions for nondisabled participants.** The adult participant or responsible family member should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the participant's recognized medical authority.

PART 1 – TO BE COMPLETED BY PARTICIPANT OR RESPONSIBLE FAMILY MEMBER. *PLEASE PRINT.*

Participant's Name: _____ Birth Date: ___/___/___ (*month/day/year*) ☐ Male ☐ Female

Responsible Family Member's Name (if applicable): _____

Phone: (___) ___ – _____ Alternate Phone: (___) ___ – _____

Address: _____ City: _____ State: _____ Zip: _____

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA) I hereby authorize

_____

(Name of Recognized Medical Authority)

to release such protected health information as is necessary for the specific purpose of special diet information to

_____

(Name of CACFP Adult Day Care Center)

and I consent to allow the recognized medical authority listed above to freely exchange the information listed on this form and in my records with the adult day care program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet. I understand that I may rescind permission to release this information at any time except when the information has already been released. My permission to release this information will expire on

_____

(Expiration Date)*

* ***Note:*** *The recommended expiration date is for a period of one year so that updates to the medical statement can be made in conjunction with the participant's annual physical.*

Signature of Participant or Responsible Family Member: _____ Date: _____

PART 2 – TO BE COMPLETED BY A RECOGNIZED MEDICAL AUTHORITY. *PLEASE PRINT.*

The Connecticut State Department of Public Health defines a ***recognized medical authority*** *as a physician, physician assistant, doctor of osteopathy or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists and certified nurse anesthetists who are licensed as APRNs.*

A. Describe the medical or other special dietary need that restricts the patient's diet:

B. List foods to be **omitted** from the diet and foods to be **substituted** (attach specific diet plan):
*Note: A specific diet plan **must** be provided before the CACFP adult day care center can make any meal substitutions for the adult participant.*

C. List foods that require a change in texture. If all foods need to be prepared in this manner, indicate "All."

☐ Cut up or chopped to bite-size pieces *(List foods):*

☐ Finely ground *(List foods):*

☐ Pureed *(List foods):*

D. List any special equipment or utensils needed:

E. Indicate any other comments about the patient's eating or feeding patterns:

Name of Recognized Medical Authority: _____ Office Phone Number: ( ) –

Signature of Recognized Medical Authority: _____ Date: _____

Office Stamp:

This form is available as a PDF document at www.sde.ct.gov/sde/lib/sde/pdf/deps/nutrition/cacfp/sdn/medical_adult.pdf and a Word document at www.sde.ct.gov/sde/lib/sde/word_docs/deps/nutrition/cacfp/sdn/medical_adult.doc.